December 2012

Montana Central Tumor Registry Newsletter

MONTANA CANCER CONTROL PROGRAMS
MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

Decades of Screening Mammography Results

Source: NEJM 2012; 367: 1998-2005 11/22/12 DOI: 10.1056/NEJMoa1206809

BACKGROUND

To reduce mortality, screening must detect life-threatening disease at an earlier, more curable stage. Effective cancer-screening programs therefore both increase the incidence of cancer detected at an early stage and decrease the incidence of cancer presenting at a late stage.

METHODS

We used Surveillance, Epidemiology, and End Results data to examine trends from 1976 through 2008 in the incidence of early-stage breast cancer (ductal carcinoma in situ and localized disease) and late-stage breast cancer (regional and distant disease) among women 40 years of age or older.

RESULTS

The introduction of screening mammography in the United States has been associated with a doubling in the number of cases of early-stage breast cancer that are detected each year, from 112 to 234 cases per 100,000 women — an absolute increase of 122 cases per 100,000 women. Concomitantly, the rate at which women present with late -stage cancer has decreased by 8%, from 102 to 94 cases per 100,000 women — an absolute decrease of 8 cases per 100,000 women. With the assumption of a constant underlying disease burden, only 8 of the 122 additional early-stage cancers diagnosed were expected to progress to advanced disease. After excluding the transient excess incidence associated with hormone-replacement therapy and adjusting for trends in the incidence of breast cancer among women younger than 40 years of age, we estimated that breast cancer was overdiagnosed (i.e., tumors were detected on screening that would never have led to clinical symptoms) in 1.3 million U.S. women in the past 30 years. We estimated that in 2008, breast cancer was overdiagnosed in more than 70,000 women; this accounted for 31% of all breast cancers diagnosed.

CONCLUSIONS

Despite substantial increases in the number of cases of early-stage breast cancer detected, screening mammography has only marginally reduced the rate at which women present with advanced cancer. Although it is not certain which women have been affected, the imbalance suggests that there is substantial overdiagnosis, accounting for nearly a third of all newly diagnosed breast cancers, and that screening is having, at best, only a small effect on the rate of death from breast cancer.

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Department of Public Health & Human Services

Meet the Registrar

Janet Axelson
Deer Lodge Medical Center

I am Janet Axelson and am the cancer registrar at Deer Lodge Medical Center in Deer Lodge, MT since 2010. I am an RHIA and a CCS-P.

I was born in Colorado Springs, CO and grew up in Butte, MT. I am a triplet (2 boys and 1 girl) and have older twin sisters. I attended Montana Tech in Butte and graduated with an AA degree. I also attended Carroll College and graduated with a BS degree in Health Information management. My work history includes Director of Medical Records at Silver Bow General Hospital until its closure, DRG Coordinator at St. James Healthcare, an independent compliance auditor for long term care facilities, acute care facilities, and assisted living facilities from 1985 to present, a coding instructor 2005-2006, and an Office Manager for a cardiac practice from 2010-2012. I have been responsible for setting up and maintaining a computer lab at our local middle school from 2000-2006. I also taught computer classes at the middle school level for 6 years.

I have been married to Jim Axelson for 33 years. He has been a licensed mortician/funeral director since 1976, owned a local funeral home and now owns a very successful cremation business in Butte. I have two sons and daughters-in-law who all live in Missoula. My older son, Cameron, is a marathon competitor and younger son, Adam, is a Regional Golden Gloves Boxing Champion. Adam now fights at the professional level. Cameron graduated from U of M with a degree in Psychology and now works for Northwest Tissue at the Missoula satellite office with coverage throughout Montana. Adam graduated from U of M with a degree in Exercise Science and also works for Northwest Tissue at the Missoula office. I have one grandson, Brayden, who is 18 months old.

My other hobbies include professional mountain bike racing to include 24 hour endurance racing from 2005-2010. I qualified for world solo championships in 2007. I also like road biking, mountain biking for pleasure having recently competed in and completed the Pikes peak Challenge in Colorado Springs, and cross country skiing. I also own a small online marketing business.

New FDA Drug Approvals

Axitinib for advanced renal cell cancer

Vismodegib for advanced basal cell carcinoma

Pertuzumab for HER2 breast cancer

Carfilzomib for multiple myeloma

Aflibercept for colorectal cancer

Enzalutamide for late-stage prostate cancer

Bosutinib for CML

Regorafenib for metastatic colorectal cancer

Omacetaxine Mepesuccinate for CML

Cabozantinib for medullary thyroid cancer

Ponatinib for rare leukemias

SEER Ask a Registrar

SEER Reference: ASW-04569

Question:
Tumor was diagnosed by MRI and CT as a right cavernous sinus meningioma which was treated with gamma knife radiosurgery. There was no tissue diagnosis. The patient was fine for 1 ½ years and following up with brain MRIs every six months. The initial mass responded well to the radiosurgery. At the patient's recent surveillance MRI, there was a new mass even larger than the original mass. This time they decided to operate and they find a malignant hemangiopericytoma with gross total resection. The patient is treated with more radiation to the tumor bed. A few months later the patient is having low back pain and a needle core biopsy of the l-5 mass is performed and is consistent with hemangiopericytoma. It is now metastatic to L-5, T-9, and the sacrum. The patient has radiation to L-5 and is placed on Sutent for chemo. Question: Is this one or two tumors? This was Initially abstracted as a meningioma, NOS. After treatment for meningioma (gamma knife) she had a recurrence in the same spot 1 1/2 years later. They did surgery and have a tissue diagnosis so we have a new diagnosis of hemangiopericytoma (malignant). There is only mention of recurrence with now hemangiopericytoma.

Answer:
When we code ambiguous terms (no tissue diagnosis), if we get tissue at a later date, we change the histology code to match the path report (9150/3). This patient has a single malignant hemangiopericytoma primary with a recurrence 1.5 years later.

Certificate of Excellence Recipients

The following facilities received a certificate for the 2012 Third Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Rogers Dermatology	Bozeman
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Associated Dermatology	Helena
Dermatology Associates	Kalispell
Hospitals:	
Billings Clinic	Billings
St. Vincent Healthcare	Billings
Bozeman Deaconess Hospital	Bozeman
Liberty Medical Center	Chester
Rosebud healthcare Center	Forsyth
VA Medical Center	Fort Harrison
Glendive Medical Center	Glendive
Sletten Cancer Center	Great Falls
Northern Montana Hospital	Havre
Central Montana Medical Center	Lewistown
Community Medical Center	Missoula
Clark Fork Valley Hospital	Plains
Roundup Memorial Health	Roundup

Update on Assigning Class of Case

Source: COC Flash—12/7/12

Over the last two or three years, a substantial number of hospitals either have purchased physician practices or have begun to hire physicians. The physician or practice is now part of the hospital. Under these circumstances, diagnosis and first-course treatment performed by those physicians are coded as having been done *by the hospital*.

- Hospital A purchased an oncology clinic to provide service to patients living some distance from the main hospital location. Patients who receive first-course treatment in the clinic must be abstracted as having treatment "in the reporting facility" as analytic Class of Case 11-14 or 21-22.
- Hospital B has several dozen physician practices spread across a large metropolitan area; the physicians are employed by the hospital. All diagnosis and first-course treatment provided by these physicians must be abstracted as part of the hospital's care (analytic Class of Case 00, 11-14, or 21-22).

The examples above illustrate that the geographic location of hospital-employed physicians does not determine Class of Case. Similarly, a practice or clinic that is not owned by the hospital but which rents space within its walls is considered "elsewhere" when patients are diagnosed or receive first course treatment there.

- An independent radiology clinic rents space from Hospital C and provides both diagnostic scans and radiotherapy treatment for many of Hospital C's patients. Patients who receive care at the clinic must be abstracted by Hospital C *only* if the patient also receives care from the hospital itself. All care given by the clinic is "elsewhere" for the purposes of assigning Class of Case. If the program wishes to abstract cases that never receive care from the hospital, those cases are assigned an appropriate non-analytic Class of Case (usually 42).

The term "staff physician" is used to refer to independent physicians who have routine admitting privileges at the hospital.

- Patients who are diagnosed in the physician's office by a physician who has routine practice privileges in a hospital and then receive first-course treatment from the hospital itself are abstracted as Class of Case 11 or 12, "initial diagnosis in a staff physician's office…." If the program wishes to abstract cases seen by staff physicians that never receive care from the hospital, those cases are assigned an appropriate non-analytic Class of Case (usually 40-41).

There are a number of ways to determine whether a clinic or physician practice is part of the hospital.

- Does the hospital own the medical records for the practice?
- Does the hospital's accrediting organization (for example, The Joint Commission) identify the practice as a single entity with the hospital or as separate from it?
- If all else fails, ask your cancer committee or hospital administration what the relationship is.

Surveillance Reports

The Cancer Surveillance and Epidemiology Program recently completed three surveillance reports on colorectal cancer, breast cancer, and cervical cancer. These reports can be found on our web page at http://www.dphhs.mt.gov/publichealth/cancer/datastatistics.shtml

Colorectal Cancer in Montana (August 2012)
Breast Cancer in Montana (November 2012)
Cervical Cancer in Montana (January 2013)